Q&A

About The Washington Medicaid Integration Partnership (WMIP)

QUESTIONS ABOUT WMIP AND THE OLMSTEAD DECISION

QUESTION: How does Medicaid Integration fit in with the Olmstead requirements?
ANSWER: WMIP supports efforts to assist individuals with disabilities to live in the community and receive services in the most integrated setting. That is the essence of the Olmstead Supreme Court decision, which suggested that states demonstrate compliance by showing that they have comprehensive and effective plans for placing qualified individuals with disabilities in less restrictive settings and waiting lists that move at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated. DSHS has been emphasizing community living since 1990 and has an Olmstead Plan.

Q: When it comes time to develop the RFP for the pilot project, will you include "most integrated setting" language and requirements?
A: Yes.

QUESTIONS ABOUT THE COVERED POPULATION

Q: Will the developmentally disabled population be included or excluded?
A: Individual clients with developmental disabilities could be included in the WMIP project in order to receive covered medical and social services through a contracted managed care provider. Some DD services will not be included in the initial model – for example, supported employment.

Q: In the RFP, will you make it clear that providers cannot discriminate based on disability, especially developmental disabilities?
A: Yes. Absolutely.

Q: If you decide to bring in more than one contractor, will you increase the population to be served?
A: WMIP could involve more than one contractor. Depending on the capacity of the contractor(s) and the provider network(s), we could increase the enrollment.

Q: Could the project enroll fewer than 4,000 enrollees?
A: At the moment, 4,000 is the minimum number of enrollees we are considering.

Q: Could you have more than one pilot site?
A: Yes, again depending on how the plan evolves.

Q: Will you have to obtain a waiver to restrict freedom of choice (cf. federal regulations about home care in cluster care arrangements)? What other waiver requirements apply?
A: We are beginning the project as a voluntary program, so freedom of choice will not be restricted and a waiver should not be necessary. We have begun conversations with CMS about implementation, because CMS has contract approval authority and will review the adequacy of the provider network. But a waiver should not be required until we reach the point of moving to a mandatory enrollment approach or including Medicare funds.

Q: In a voluntary population, how do you avoid adverse selection -- or conversely, how can you avoid getting just the "cream at the top"?
A: The "opt-out" method increases the distribution of the population across the risk groups. The Department of Social and Health Services (DSHS) will also approve all enrollment materials to ensure no unfair marketing is used to only enroll healthier clients. DSHS will also work with its actuaries to adjust rates for selection in its rate-setting methodology.

QUESTIONS ABOUT THE WMIP TIMEFRAME

Q: What has changed in the timeline as a result of the CMS Capitated Disease Management Demonstration RFP?

A: Because of the great advantages of integrating Medicare and Medicaid capitation for our dually eligible clients, we are going to wait for the results of the CMS RFP before making further decisions about procurement for Medicaid Integration.

Q: If you want to see system change and really make an impact, why are you allowing such an extended timeline?
A: We purposefully allowed a long time frame from contracting to implementation in order to obtain CMS approval, educate clients and providers, and build the necessary system infrastructure. However, if those things are accomplished faster, an earlier start date would be acceptable. CMS' demonstration asks for a start date of January 2004.

Q: How long will the demonstration continue?
A: We need at least two years experience to evaluate outcomes, plus an additional 18 months of mandatory enrollment before we can evaluate that approach. Beyond this formal evaluation, however, our hope is that we will experience early success and continue building on it.

QUESTIONS ABOUT RATES AND INCENTIVES

Q: If you have the PMPM cost and your intent is that the project not cost any more money, don't you already have the information to know what the rates would be?
A: Although average historical costs are known, the costs related to the individuals who selectively enroll in the program are unpredictable. We also have to take into account new technology, procedures, tests, and drugs that continuously increase medical costs.

Q: Do you intend to take the savings "off of the top" to push the risk down to the contractors?
A: The rate will undoubtedly be a discount off the fee for service rates currently paid for services.

Q: Will there be a shared savings arrangement between partners and the entity at risk?
A: Possibly. Some other state integration projects did not have a shared savings arrangement at the start, as systems were not set up to administer such a process. Those systems were developed and now do have shared savings.)

QUESTIONS ABOUT MODELING

Q: Will the RFP include detail of the care models that the State expects?
A: Yes.

Q: Are you looking at differences in urban and rural areas? What best practices would apply to such a project in unique populations?
A: Ideally, we would like to see WMIP implemented in both urban and rural settings. We expect respondents to the RFP who have the capacity to serve clients in rural areas to address issues that are relevant to the special needs of a rural population, and to identify the best practices they will employ.

QUESTIONS ABOUT OTHER PILOTS AND POPULATIONS

Q: Has there been any thought given to including children's services and a corrections population?
A: No. While these other dimensions may eventually benefit from integrated approaches, they were not part of the original WMIP charter from DSHS Secretary Dennis Braddock.

Q: The RFI talked about the major integration pilot as well as different "smaller" pilots. Are there going to be other populations targeted for pilots?
A: Some decisions have been made about additional targeted projects to save money and improve outcomes for clients. Because of staffing concerns, projects are selected based on their potential for success. (See the table at the end of this document for a list of those projects and contact names and phone numbers.)

Q: How will people be able to apply for the "smaller projects?"
A: The RFI produced a number of suggested projects that focused on smaller targeted populations. Because of the time involved in working on the development and eventual implementation and management of these projects, and the fact that DSHS is taking on this additional workload with existing staff, we must prioritize the list. That means the projects that offer the most potential for achieving the greatest amount of savings and the best chance for improving client outcomes will be worked on first. Please feel free to send project ideas or suggestions to the WMIP Agency Leads with your analysis of how cost savings can be achieved.

Q: Will the smaller pilots be posted on the web site?
A: Yes. Information of interest to WMIP , including data projects to identify targeted populations, will be posted at the WMIP site: http://maa.dshs.wa.gov/MIP

QUESTIONS ABOUT DATA AND WHERE TO FIND IT

Q: Are you able to back out the costs of services that may be eliminated from the Medicaid program in the future?
A: Yes, it is possible to identify specific types of services from the Medicaid-paid claims data and to remove costs for these services for any type of service that might be eliminated from the Medicaid program in the future.

Q: Can you break out DME expenditures?
A: Yes. DME expenditures are broken out in the appendix tables A-1, B-1, and C-1 under "Medical Assistance Administration" subcategory "Durable Medical Equipment." The number of clients, total amounts paid during FY2001, and amount paid per client are shown for Medicaid-only, dual eligible, and GA-U clients. These tables and other data will be posted on the Web site.

Q: Can you break out individual level data on request?

A: It is not possible to provide individual-level data at this time since the integrated database used for WMIP analyses to data was constructed under the limited authority of the agency to use linked confidential data for its own internal purposes. It may be possible to construct a public-use datafile in which individual identifiers have been removed and the necessary arrangements have been made to release confidential information for such services as drug and alcohol treatment or mental health treatment which are protected under specific state and federal laws. The work to prepare a public-use datafile would be extensive and is not currently in the Workplan.

Q: Can you break out detailed county level data?
A: Analyses of data at the county or RSN level are planned, and once they are prepared, they will be available through the Web site.

Q: Can you break out detailed level data regarding diagnosis codes?
A: Yes, preliminary work has demonstrated that such break-downs are possible. Further analyses will be conducted during the next several months to determine the most appropriate ways to tabulate data according to diagnosis since most clients have multiple diagnoses during a given year. Once these analyses are complete, the tables will be available.

Q: Are Medicaid clients with developmental disabilities going to be excluded from the data or will they be included if they are receiving other DSHS services from other programs, such as the Medical Assistance Administration (MAA), Aging and Adult Services Administration (AASA), the Mental Health Division (MHD), or the Division of Alcohol and Substance Abuse (DASA)?
A: In the data tables being prepared, aged, blind or disabled clients with developmental disabilities are included in counts of clients eligible for Medicaid, Medicaid and Medicare, or GA-U during FY2001. In addition, if any of these clients who have developmental disabilities received services from MAA, AASA, MHD, or DASA, they will be included under the counts of clients and expenditures for clients served. The costs for services provided by the Developmental Disabilities Division will not be included.

Q: I assume that most, if not all, adult clients of the Developmentally Disabilities Division (DDD) also receive services from MAA, so were people with developmental disabilities taken out of the MAA numbers?
A: Adult clients of DDD who receive services from MAA are included in the counts of eligible clients as long as they are eligible for Medicaid, Medicaid and Medicare or GA-U under the aged, blind or disabled programs. Also, costs for MAA services and DDD clients who receive these services will be included in the WMIP data tables.

Q: Will data analyses be prepared for people who are Medicaid clients and receive service from the DDD be done?
A: Analyses of the costs for DDD services have been completed and were provided to the Director of the Division of Developmental Disabilities.

Q: Where will the tables on expenditures and use of DSHS services be available?
A: The tables showing expenditures and use of DSHS services for Medicaid-only, dual eligible (Medicaid and Medicare), and GA-U clients will be on the WMIP website by mid-February 2003. Future analyses will be released periodically on the same Web site (**http://maa.dshs.wa.gov/MIP**) as they are completed.

OTHER TARGETED INTEGRATION PROJECTS

Project Description	Contact Person
Small health-LTC pilot projects. ADSA and MAA will develop specific work plans to implement an "Enhanced Case Management for Clients with Immobility Project" and at least one Adult Day Health-Adult Family Home Pilot. These projects coordinate health and long-term care for specific target populations (under 500 clients). The intention is to implement these projects by July 1, 2003 via negotiation with interested providers.	Bill Moss/Susan Fleskes
Promote Medicare eligibility. ADSA, HRSA, and MAA will ensure that clients potentially eligible for Medicare receive prompt enrollment assistance, thus reducing unnecessary Medicaid expenditures.	Bill Moss/Susan Fleskes
Maximize access to veterans' benefits. ADSA will develop strategies to secure VA aid & attendant benefits for eligible Medicaid clients.	Bill Moss/Bill Allman
Third party insurance for children. (six month pilot) Division of Child Support is reengineering its medical enforcement processes to provide better data to MAA that will lead to better cost avoidance and cost recoveries for Medicaid.	Steve Strauss/ Clyde Takeuchi
Behavioral health data analysis. MAA, HRSA and RDA will conduct specialized data analysis regarding whether the provision of behavioral health services will produce savings in health care and other state agency budgets.	Sharon Estee/Darleen Vernon/Nancy Anderson
Chemical Dependency counselors in Emergency Rooms. DASA and MAA will work together on a project to promote referral to CD treatment in ERs when appropriate.	Fred Garcia/Robin McIlvaine